June 13, 1997

SUMMARY OF CHAIRMAN'S MARK

MEDICARE

PRINCIPLES

1. Preserve and protect the Medicare program for current and future beneficiaries.

2. Establish the framework for a restructured Medicare program, building on models that have proven effective in other arenas, such as the Federal Employees Health Benefit Plan.

3. Provide seniors with information and allow them to choose from a variety of health plan options according to their own priorities and preferences. Maintain the traditional Medicare program as an option.

4. Implement policies to reduce the rate of growth in spending in the traditional Medicare program.

5. Eliminate waste, fraud and abuse.

MEDICARE CHOICE

A new "Medicare Choice" program is created. Medicare Choice builds on the existing Medicare program which allows health maintenance organizations (HMOs) to enter into risk contracts with the Health Care Financing Administration. Under Medicare Choice, Medicare beneficiaries will have the opportunity to choose from a variety of private health plan options the health care plan that best suits their needs and preferences.

The new Medicare Choice program will operate as follows:

1. Types of Medicare Choice plans :
   a. Full fee-for-service plans **-FFS**
   b. Preferred Provider Organizations - **PPOs** (fee-for-service plans with incentives to use network providers)
   c. Point of Service Plans - **PoS** (Closed networks with some option to choose out-of-network providers at greater cost-sharing)
   d. Provider Sponsored Organizations **-PSOs** (closed networks operated by providers)
   e. Health Maintenance Organizations **-HMOs** (Closed provider networks)
   f. Medical Savings Accounts combined with a qualified high-deductible policy **- MSAs**. (Demonstration)

g. Any other type of health plan that meets plan eligibility standards.

2. Eligibility : All Medicare beneficiaries enrolled in both Part A and Part B are entitled to enroll in a Medicare Choice plan available in their area of residence, except those with end-stage renal disease who were not already enrolled in a Medicare Choice plan at the time of diagnosis.

3. Enrollment : Medicare Choice plans must hold open enrollment during specified times including during the coordinated open enrollment period held every November. Plans may enroll beneficiaries at other times. Enrollment activities will be conducted by the Medicare Choice plans.

4. Disenrollment : As under current law, Medicare enrollees may disenroll from a Medicare Choice plan at any time; disenrollment will be effective on the first day of the following month. There will be an exception for Medicare Choice MSA plan holders who can only enroll and disenroll during the coordinated enrollment period in November and during other specified special circumstances.

5. Information : Comparative information on each Medicare Choice plan will be compiled and distributed by the Secretary to all eligible individuals during the coordinated open enrollment period in November of each year. Also, all plans will be required to have this information available to provide to any eligible Medicare beneficiary upon request.

6. Marketing : Marketing strategies and materials must comply with standards and receive prior approval by the Secretary.

7. Benefits :
   a. Must cover current Medicare-covered items and services;
   b. May incorporate extra benefits in basic package; or
   c. May offer supplemental benefits, priced separately from basic package.

8. Beneficiary protections including :
   a. Must provide access to urgent and emergency services 24 hours a day, 7 days a week;
   b. Definition of emergency services based on "prudent layperson" standard;
   c. Must have accreditation for meeting quality standards and have ongoing external quality review;
   d. Must have consumer protections:
      (1) Appeals and Grievance procedures;

(2) Non-discrimination based on health status.

9. Medicare choice plan eligibility standards including :
   a. Must have State licensure;
   b. Must assume full risk for Medicare benefits;
   c. Must meet solvency requirements;
   d. Must meet minimum enrollment requirements.

10. Limited exceptions for PSOs :
Provider Sponsored Organizations would be subject to the same standards as other Medicare Choice organizations with some exceptions: Federal pre-emption of state licensure for a maximum of three years. A State can recommence licensure as soon as it demonstrates that its licensure requirements meet certain Federal standards.

11. Medicare payment :
For each year through 2002, the Medicare payment for each county will equal the highest of the following:
   a. A phased-in blend of local and national payment rates (50% local and 50% national by 2002).
   b. A minimum payment amount ($350 in 1998); or
   c. A minimum percent increase over the previous year.

Payments for graduate medical education (GME) and disproportionate share (DSH) will be carved out of the local rates over four years.

The annual inflation update will be annual per capita GDP plus .5 percentage point.

A risk adjuster will be applied to new enrollees. The adjustment will be 5% for the first year of enrollment and will decrease by 1% for each subsequent year of enrollment.

12. Preemption of State Premium Taxes :
The current law on federal preemption of state premium taxes or fees on Federal payments from the FEHB fund to health plans will be extended to Federal payments to Medicare Choice plans and other health plans receiving capitated payments from the Medicare Trust Funds.

13. Medicare supplemental insurance ("Medigap"):
   a. Allow portability of Medigap policies . Current law "guaranteed issue" requirements for Medigap policies will be expanded to cover certain circumstances -- including when an individual decides to return to traditional Medicare within one year of their first enrollment in a Medicare Choice plan.

b. Pre-existing condition exclusions. Insurers will no longer be allowed to impose pre-existing condition exclusions on beneficiaries enrolling during guaranteed issue periods.

c. New Medigap high deductible option. A new standard Medigap benefit plan will be authorized which allows an annual $1500 deductible before the policy begins paying benefits.

14. PACE Program:
The Program for All-inclusive Care for the Elderly (PACE), which provides health and long-term care services on a capitated basis to frail elderly persons at risk of institutionalization, would be converted from a demonstration project to a permanent benefit category eligible for coverage and reimbursement under the Medicare program.

15. Demonstration Projects

a. Medicare Medical Savings Account (MSA)Demonstration
Medicare beneficiaries will have the option of choosing a high deductible Medicare Choice plan and having contributions made by the Secretary to a Medicare Choice MSA. The demonstration would be capped at 500,000 enrollees and would sunset December 31, 2002.

b. Competitive Pricing Demonstration. A demonstration program will be established to test mechanisms in which payments to Medicare Choice plans are determined through a competitive pricing process.

c. Medicare Enrollment Demonstration. A demonstration program will be established for using a third-party contractor to conduct the Medicare Choice plan enrollment and disenrollment functions in an area, to be conducted separately from the competitive pricing demonstrations.

d. Social Health Maintenance Organizations (SHMOs). The existing SHMO demonstration projects will be extended through 2000 and enrollment will be expanded for each demonstration from 12,000 to 36,000.

e. Community Nursing Organization Demonstration Projects. This demonstration project which tests a prepaid capitated, nurse-managed system of care will be extended for an additional period of 2 years.

16. Commissions
Two commissions are established:

a. National Bipartisan Commission on the Future of Medicare: A 15-member commission will be established for one year and charged with making recommendations to Congress on actions necessary to ensure the long term fiscal health of the Medicare program.

b. Medicare Payment Review Commission: A 15-member commission will replace the existing Physician Payment Review Commission and the Prospective Payment Review Commission. The new commission will submit an annual report to Congress on the status of Medicare reforms, and make recommendations on Medicare payment issues and related issues affecting the Medicare program.

Preliminary CBO score: -26.1 b total Medicare Choice
+ 7.3 b. pay back for GME/DSH
-18.8 b. net

(Note: preliminary CBO scores are for the period 1998-2002 and do not account for interactions)

CHANGES TO THE TRADITIONAL MEDICARE PROGRAM

PPS HOSPITALS

17. Establish a calendar year cycle for the annual hospital inflation update starting with CY 1998. CY 1998 update is equal to market basket (MB) minus 2.5 percentage points and MB minus 1 percentage point for CY 1999-2002.
Preliminary CBO: score: -$13.9 b .

18. Reduce hospital payments for inpatient capital (i.e., land, buildings) 10 percent for FY 1998-2002. Adjust payments to provide reimbursement for property taxes.
Preliminary CBO: score: -$4.3 b.

19. Amend current capital payments for capital asset sales to reflect the sales price equal to book value (applicable to hospitals and skilled nursing facilities).
Preliminary CBO score: included in #17 above

20. Apply hospital transfer policy to patients placed in skilled nursing facilities and PPS-exempt facilities (April, 1998, also apply to transfers to home health agencies).
Preliminary CBO score: -$3.7 b.

21. The Secretary shall establish a new hospital disproportionate share (DSH) formula beginning in CY 1999 to reflect hospitals carrying large uncompensated care caseloads. Phase-down DSH payments to an annual average reduction of 4.0 percent of what they would have otherwise have been each year FY 1998-2002.
Preliminary CBO score: -$2.4 b.

22. Eliminate graduate medical education and disproportionate share add-ons for outlier payments.
Preliminary CBO score: -$2.1 b.

23. Reduce bad debt payments to providers to 75% during FY 1998, 60% during CY 1999, and 50% in future years.
Preliminary CBO score:-$0.6 b.

24. Increase payments to Puerto Rico's hospitals by altering the blended formula for the standardized amount from the 75% local rate, 25% Federal rate to a 50%/50% blend.
Preliminary CBO score: $0.03 b.

25. Establish permanent payment for hemophilia clotting factor.
Preliminary CBO score: 0.0

PPS-EXEMPT HOSPITALS

26. Establish a PPS for rehabilitation hospitals FY 2001, and collect data to establish a PPS for long-term care hospitals.
Preliminary CBO score: $0.4 b.

27. Reduce the annual hospital inflation update for all PPS-exempt hospitals by 1.5 percentage points for FY 1998-2002. Update would be higher for facilities with low reimbursements, and scaled down to zero for highly reimbursed facilities.
Preliminary CBO score: -$4.4 b.

28. Reduce incentive payments to the lesser of:
    (a) 10% of (TARGET minus COSTS), or
    (b) 1% of COSTS
Preliminary CBO score: included in #24

29. Change relief payments so that they apply only to those facilities in greatest need (with costs that are at least 10% above their target).
Preliminary CBO score: included in #24

30. Reduce hospital capital payments for rehabilitation, long term care, and psychiatric hospitals by 15 percent for FY 1998-2002.

Preliminary CBO score: included in #24

31. Adjust cost limits for existing rehabilitation hospitals, long term care hospitals, and psychiatric hospitals. Low cost hospitals would be adjusted so that they would not be less than 50 percent of the national average, and the maximum amount reimbursed would be limited to the 90th percentile of each category of hospitals' cost limits.
Preliminary CBO score: included in #24

32. Establish new payment criteria for all start-up facilities, so that cost limits do not exceed 130 percent of the national average.
Preliminary CBO score: included in #24

33. Grandfather long-term care hospitals that were established within a hospital prior to September 30, 1995.
Preliminary CBO score: included in #24

GRADUATE MEDICAL EDUCATION

34. Phase-down the hospital indirect medical education (IME) payment adjustment from 7.7 percent in FY 1997 to 7.0 percent in FY 1998; 6.5 in FY 1999; 6.0 percent in FY 2000; 5.5 percent in 2001 and after. Establish a cap on number of residents counted in IME formula.
Preliminary CBO score:-$5.6 b.

35. Establish a cap on the number of residents supported by Medicare direct medical education (DME) payments. Allow payments to rural health clinics and Federally qualified health centers.
Preliminary CBO score:-$0.7b.

36. Payment of GME carve out ("pay back") from HMO payments to teaching hospitals serving Medicare managed care enrollees.
Preliminary CBO score: $7.3b

OUTPATIENT HOSPITAL DEPARTMENTS

37. Outpatient hospital:
    a. Eliminate formula-driven overpayments in FY 1998; extend capital and non-capital cost limits;
    b. Establish a prospective payment system (PPS) for outpatient hospital services for FY 1999;
    c. Reduce beneficiary outpatient cost-sharing.
Preliminary CBO score: -$7.2 b.

HOSPICE

38. Require payments based on location of individual's home.
Preliminary CBO score: -$0.0*

39. Restructure hospice benefit:
    a. Allow two 90 day periods, followed by unlimited 60 day periods with physician certification;
    b. Allow greater flexibility in services provided;
    c. Allow hospices to contract for physician services;
    d. Waive rural staffing requirement;
    e. Establish waiver of liability for individuals who are not in fact terminally ill; and
    f. Allow greater flexibility for the timing of physician certification.

Preliminary CBO score: $0.0*

SKILLED NURSING HOMES (SNFs)

40. Temporary extension for routine cost limits for FY 1998.
Preliminary CBO score: included in #39

41. Establish a case-mix adjusted per diem prospective payment system for all SNF costs (i.e. routine, ancillary, and capital-related). Transition is over four years where facility specific payments are blended with national prospective rates.
Preliminary CBO score: -$8.3 b.

HOME HEALTH SERVICES

42. Interim payment for home health services for FY 1998-1999 combines reduced cost limits for visits with an agency-specific per beneficiary annual limit calculated from the agency's cost reporting period ending in 1994.
Preliminary CBO score: -$15.6 b.

43. Prospective payment system to be implemented in FY 2000.
Preliminary CBO score: included in #40

44. Base payment on location where home health service is furnished.
Preliminary CBO score: included in #40

45. Eliminate periodic interim payments simultaneous with the implementation of home health prospective payment.
Preliminary CBO score: included in #40

46. Clarify the home health benefit:
    a. Part-time and intermittent nursing care.
    b. Require the Secretary to study and recommend appropriate homebound criteria.

Preliminary CBO score: included in #40

47. Beginning in 1998, establish a 100 visit post-hospital home health benefit under Part A, with all other visits considered part of a new Part B home health benefit. Payments for the new Part B home health benefit will be paid partly from the Part A Trust Fund for a seven year phase-in period.

48. Consistent with other Part B services, establish beneficiary cost-sharing for Part B home health services at $5 per visit, billable on a monthly basis, capped at an amount equal to the annual hospital deductible.
Preliminary CBO score: -$4.9 b.

49. The Medicare Explanation of Benefits notice will include home health care benefits provided and billed for.
Preliminary CBO score: included in #40

NEW OR ENHANCED PREVENTION BENEFITS

50. Mammography screening -- Annual mammograms for women at age 40.
Preliminary CBO score: $0.1 b.

51. Colorectal cancer screening -- Secretary to specify coverage policy. **Preliminary CBO score: $0.6 b.**

52. Diabetes self-management -- Provide payment for diabetes self-management education; payment for monitors and testing strips to individuals with Type II diabetes; reduce by 10 percent payment for testing strips.
Preliminary CBO score: $2.4 b.

PHYSICIANS AND OTHER HEALTH PROFESSIONALS

53. Physician fee schedule:
    a. Establish one conversion factor for all physician services; and
    b. Revise the physician payment update formula.
Preliminary CBO score:-$5.3

54. Provide a 4-year transition period (1998-2001) for implementing new method of calculating practice (i.e., office) expenses, with approximately 10-percent of the transition to be implemented in 1998.
Preliminary CBO score: $0.0

55. Provide expanded direct reimbursement for nurse practitioners and physician assistants.
Preliminary CBO score: $0.5 b.

LABORATORIES

56. Reduce annual inflation updates by minus 2 percentage points for 1998-2002; lower cap to 74 percent of median for payment amounts.
Preliminary CBO score: -$1.5 b.

57. Provide for specialized carriers to process laboratory claims and uniform national rules for coverage.
Preliminary CBO score: $0.0

DURABLE MEDICAL EQUIPMENT

58. Reduce annual inflation update for all durable medical equipment by 2 percentage points for 1998-2002.
Preliminary CBO score:-$0.6 b.

59. Reduce the monthly payment amount for home oxygen by 25 percent in 1998 and an additional 12.5 percent in 1999, with no update in those years.
Preliminary CBO score:-$2.2 b

OTHER PART B SERVICES

60. Establish a fee schedule for ambulance services, and reduce the annual inflation update by one percentage point.
Preliminary CBO score:-$0.1 b.

61. Reduce annual inflation updates for ambulatory surgical centers by 2 percentage points.
Preliminary CBO score:-$0.4 b.

62. Provide for new payment rules for outpatient prescription drugs.
Preliminary CBO score:-$1.0 b.

BENEFICIARY PREMIUM

63. Establish in permanent law beneficiary premiums at 25 percent of program spending (including home health benefit).
Preliminary CBO score: -$12.3 b.

RURAL

64. Rebase sole community hospitals allowing them to use FY 1994 or FY 1995 costs.
Preliminary CBO score: $0.6 b.

65. Reinstate special payments to Medicare dependent hospitals.

Preliminary CBO score: $0.2 b.

66. Expand the Medicare EACH-RPCH program to all states. Retain reimbursement for facilities under the current demonstration program.
Preliminary CBO score: $0.2 b.

67. Grandfather rural referral centers (RRCs) designated since FY 1991, and for reclassification purposes exempt RRCs from having to meet the 108% average hourly wage (AHW) threshold for the statewide rural AHW.
Preliminary CBO score: $0.0 b.

68. Reform Medicare payments to Rural Health Clinics (RHCs):
    a. Extend per-visit payment limits to provider-based clinics;
    b. Require triennial recertification;
    c. Limit the nurse practitioner/physician assistant (NP/PA) waiver to clinics already certified, new clinics will have to meet the NP/PA staffing requirements; and
    d. Require clinics to meet performance standards.
Preliminary CBO score: -$0.2 b.

OTHER PROPOSALS

69. Extend permanently current Medicare secondary payer policies (MSP), including for beneficiaries who are disabled and have end-stage renal disease (ESRD). For ESRD beneficiaries, also increase to 30 months the time period Medicare is secondary payer.
Preliminary CBO score:-$7.5 b.

70. Clarifications of Medicare secondary payor policies regarding time and filing limits.
Preliminary CBO score:-$0.4 b.

71. Anti-fraud and abuse penalties and program integrity safeguards:
    a. Additional exclusion and civil monetary penalty authority;
    b. Improvements in protecting program integrity (surety bonds and accreditation; requirement to provide EIN and SSN; requirement to furnish diagnostic information; non-dischargeability of Medicare penalties);
    c. Inherent reasonableness/authority for fee schedules.
Preliminary CBO score: -$0.2b

72. Require SNFs bill for all Part B services (with the exception of physician services).

Preliminary CBO score: included in #39

OTHER PROVISIONS FOR MEDICARE TRUST FUND SOLVENCY

73. Conform the eligibility age for Medicare to the eligibility age for Social Security.
Preliminary CBO score: $0.0 b.

74. Extend the Medicare Hospital Insurance tax to all state and local government employees.
Preliminary CBO score: -$6.9 b. (not counted towards savings or revenue instructions)

MEDICAID

PRINCIPLES

- Enhance the ability of the Federal and State governments to meet the health care needs of vulnerable populations.
- Slow the rate of growth in spending on Medicaid.
- Improve management of the program.
- Increase access to health care coverage for children by building on existing relationships between the federal government and the states.

MANAGEMENT FLEXIBILITY REFORMS

1. Mandatory managed care without waivers .
   States will be permitted to mandate enrollment of individuals in managed care plans without the need for waivers.
   a. Requirements that provide barriers to managed care will be removed (e.g., “75/25" requirement; “freedom of choice;” statewideness, etc.) for enrollees in managed care only;
   b. The threshold for federal review of contracts will be changed from $100,000 to $1 million.
   c. Establishes rules for using Primary Care Case Management (PCCM).
   e. Quality standards for managed care, including consumer protections will be established.

   Preliminary CBO Score: $0 billion

2. Repeal Boren Amendment
   a. Provider payment issues will be determined exclusively by the states. There will be no federal right of action for providers.
   b. States must provide public notice of proposed payment rates and the methods used to establish rates, for institutional providers of services under the state plan.

   Preliminary CBO score: -$1.2 billion

3. Allow Medicaid rates for cost sharing for QMBs and dual eligibles as payment in full.
   Clarifies the Medicaid statute to prevent providers from claiming Medicare cost sharing for QMBs and dual eligibles

in excess of Medicaid rates.
Preliminary CBO score: -$600 million (net of Medicare effect)

4. No Waiver Required for Provider Selectivity
   a. States will be permitted to negotiate rates by contracting exclusively with selected providers without the need for a waiver.
   b. States will be permitted to contract with, on a capitated basis or otherwise, health care plans, individual health care providers, or other entities for the provision of medical assistance, for case management services, or for coordination of medical assistance.

Preliminary CBO score: $0

DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

5. DSH allotments are reduced by imposing freezes, making graduated proportional reductions, and reducing payments by amounts claimed for mental health services.
Preliminary CBO score: pending

EXPANSION OF MEDICAID ELIGIBILITY

6. State option to permit workers with disabilities to buy into Medicaid
States would have the option to allow disabled SSI beneficiaries with incomes up to 250 percent of the FPL to "buy into" Medicaid by paying a premium. Premium levels would be on a sliding scale, based on the individual's income as determined by the state.
Preliminary CBO score: $0

EXPANSION OF MEDICAID BENEFITS

7. Optional PACE benefit package for dual eligibles
States could offer Programs of All-inclusive Care for the Elderly (PACE) as an optional benefit to serve individuals who are eligible for Medicare and Medicaid.
Preliminary CBO score: $0

MANAGEMENT AND PROGRAM REFORMS

8. Identification and enrollment requirements
States would retain the option of purchasing private insurance, but would be relieved of administrative identification and enrollment reporting requirements.

9. Reporting requirements for certain providers.
Repeal requirement on states to specify payment rates for obstetric and pediatric services in state plans and report annual data to the Secretary on payment rates.

10. Eliminate specialized physician qualification requirements.
Eliminate prohibition on payment for services unless physician meets certification requirements of speciality boards or of the Secretary (strike 1903(i)).

11. Reduce state plan personnel requirements .
Personnel requirements under the state plan provided in 1902(a)(4)(b) would be eliminated.

12. Cost Sharing .
Limited cost-sharing is permitted for benefits for individuals who are not required to be covered by federal law. No cost sharing would be allowed for benefits to individuals who are required to be covered under federal law except as allowed under current law or any waiver granted to any state. Cost-sharing charges cannot be counted as state expenditures for purposes of matching requirements.

13. Amend criminal penalties for asset divestiture . Section 217 of "Health Insurance Portability and Accountability Act of 1996" (HIPPA) will be amended to provide sanctions only against those individuals who, for a fee, assist another individual to dispose of assets in order to qualify for Medicaid. The individual who knowingly and willfully disposes of assets may still be subject to a period of ineligibility.

14. Study on EPSDT benefits .
Not later than one year after the date of enactment, the Secretary of HHS, in consultation with governors, state Medicaid directors, the state maternal and child health directors, the Institute of Medicine, and the American Academy of Pediatrics, shall provide for a study on EPSDT benefits.

MISCELLANEOUS

15. The FMAP for the District is increased to 60 percent for each of the fiscal years beginning October 1, 1997 and ending September 30, 2000.
Preliminary CBO score: $300 million

16. For FY 1998, the caps for the commonwealths and territories are raised from the FY 1997 levels by the following amounts:
    a. Puerto Rico: $30 million
    b. Virgin Islands: $750,000
    c. Guam: $750,000
    d. Northern Mariana Islands: $500,000
    e. American Samoa: $500,000

    Preliminary CBO score: pending

CHILD HEALTH INITIATIVE

COST OF INCREASED MEDICAID PARTICIPATION

The child health initiative assumes there will be an increase in participation in the Medicaid program due to:

1. States would be permitted to provide a full continuous 12 months of Medicaid eligibility for children.
   Preliminary CBO score: $700 million

2. Increased Medicaid enrollment as a result of outreach activities.
   Preliminary CBO score: $700 million

STATE OPTION TO CHOOSE

3. Choice
   States will be given a choice in how they choose to participate in the child health initiative. Each state may choose to spend its allotment through:
   a. a capped grant; or
   b. through an enhanced federal match to expand its Medicaid program.

4. Allotment
   Each state will be guaranteed a fixed allotment based on its percentage of children in the nation who live in families with income less than 200 percent of the federal poverty level.

5. State matching requirement
   In both options, a state match is required.

6. Outreach
   In both options, states will be required to use an amount equal to 1 percent of the new funds for outreach activities, including identification and enrollment of children who are eligible for Medicaid and public awareness campaigns to encourage employers to provide health insurance coverage for children.

INCOME SECURITY

CONTINUE SSI ELIGIBILITY FOR CERTAIN NONCITIZENS

1. SSI eligibility will be maintained for all legal noncitizens who were in the U.S. and receiving SSI benefits as of August 22, 1996.

2. Legal noncitizens who were in the U.S. on August 22, 1996, will be eligible to qualify for SSI disability benefits for a limited period of time in the future.

3. SSI eligibility of refugees, asylees, and Cuban and Haitian entrants will be extended from 5 to 7 year.

Budget target: $9.7 billion

ESTABLISH "WELFARE TO WORK" PROGRAM

4. "Welfare to Work" State Grants
   a. $3 billion of funds will be available for states to assist long-term welfare recipients or those who are at risk of long-term dependency.
      i. 75 percent of the funds will be provided through formula grants to the states. The formula will be based on the state's population under the national poverty level, unemployment rates, and welfare caseload; a small state minimum will apply.
      ii. 25 percent of the funds will be awarded by the Secretary of HHS based on competition.
   b. The grants will be administered through state TANF programs.
   c. $100 million of funds provided in 2001 will be reserved to be distributed among the states based on their performance in increasing the earnings of long-term welfare recipients or who are at risk of long-term welfare dependency.

5. Use of Grant Funds

   Funds will be used to assist long-term welfare recipients or those who are at risk of long-term dependency move into the workforce including for:
   a. job creation through public or private sector employment wage subsidies;
   b. on-the-job training;
   c. contracts with job placement companies or public job placement programs;
   d. job vouchers; and,

e. job retention or support services if such services are not otherwise available.

Preliminary CBO score: $3 billion

AUTHORIZE DEMONSTRATION AUTHORITY FOR INTEGRATED ENROLLMENT SERVICE SYSTEMS FOR HEALTH AND HUMAN SERVICES PROGRAMS

6. The Secretary will be authorized to approve up to 10 state projects which integrate the eligibility and enrollment determination functions for federal and state health and human services benefit programs.

7. The integrated enrollment service system as submitted by a state to the Department of Health and Human Services and the Department of Agriculture will be deemed approved and eligible for federal financial participation.

8. Each project will be required to provide an evaluation as to the effectiveness in improving client service.

H.R. 1048, "WELFARE REFORM TECHNICAL CORRECTIONS ACT OF 1997"

9. H.R. 1048, the "Welfare Reform Technical Corrections Act of 1997" with the following modifications:

   a. Delete all provisions relating to Title II of the Social Security Act.
   b. Add a correction to the sanction for failure to meet minimum participation rates.

   Preliminary CBO score: $0

UNEMPLOYMENT INSURANCE PROVISIONS

10. Increase the Federal Unemployment Account ceiling from 0.25 percent to 0.50 percent of covered wages.

11. Clarify that states have full discretion in setting their own Unemployment Insurance (UI) base periods for determining eligibility for unemployment insurance benefits.

12. Inmates of penal institutions who participate in prison work programs will not be eligible for coverage under the Federal Unemployment Tax Act(FUTA) programs for such prison work.

    Preliminary CBO score: -$1 billion

EARNED INCOME CREDIT

1. Deny EIC Eligibility for Fraud -- A taxpayer who fraudulently claims the EIC would be ineligible to claim the credit for a period of 10 years. A taxpayer who erroneously claims the EIC due to recklessness or intentional disregard of the rules would be ineligible to claim the EIC for a period of two years.

2. Recertification Requirement -- A taxpayer who has been denied the EIC as a result of deficiency procedures would be ineligible to claim the EIC in subsequent years unless the taxpayer can provide evidence that eligibility requirements are met.

3. Due Diligence Requirements for Paid Preparers -- Return preparers would be required to meet certain due diligence requirements with respect to returns they prepare claiming the EIC.

Joint Tax: Raises $88 million over five years

REGARDING THE ACCURACY OF THE CONSUMER PRICE INDEX (CPI)

Inclusion of S.Res.50 into the Chairman's mark.

DEBT LIMIT

In addition to the spending and revenue reconciliation bills, the Senate Finance Committee has been reconciled with increasing the statutory limit on the public debt to $5.950 trillion. The current debt ceiling of $5.5 trillion is expected to be reached in early 1998. The Chairman's mark includes the required increase to $5.950 trillion.

It is assumed that the $5.950 limit will be sufficient to allow the government to operate until sometime in late 1999. The debt limit bill has been included in the spending reconciliation instructions to the Finance Committee.